Read in the Substack app Open app

Hospitals are killing patients because they don't feel like doing infection control

We now know COVID is fully airborne. We also know how to control airborne disease. So why are vulnerable people still dying of hospital-acquired COVID?

JULIA DOUBLEDAY
AUG 23, 2023

People who have gone “back to normal” (ignore the existence of COVID-19) often justify their decision by pointing to their own health status as “not high risk”. Implicit in this statement is the existence of a high-risk group of people who should still be taking COVID precautions. Also implicit is the abandonment of collective care and public health, since the “back to normal” crowd places the burden of COVID precaution on disabled, immunocompromised and vulnerable people alone.

For the most part, high risk groups indeed shoulder this burden alone. They are no longer safe in public and many limit their time in critical spaces like grocery stores and pharmacies; forget going to concerts or other “inessential” activities. Millions of Long COVID patients in particular, all too aware of what a single COVID infection can do, have to expend inordinate time, energy, and money simply to continue existing in a society hellbent on infecting them again and again and again. But you might guess that healthcare settings- specifically designed to accommodate the sick and injured- are still a safe haven for vulnerable groups.

© 2023 Julia Doubleday · Privacy · Terms · Collection notice
Substack is the home for great writing

The Gauntlet is a reader-supported publication.
To receive new posts and support my work,
consider becoming a free or paid subscriber.

Type your email... Subscribe

Guess again! As COVID continues to cycle through new variants and surges, hospitals are stripping away **even the inadequate infection control measures they implemented at the beginning of the pandemic**. Come in for heart surgery, leave with a heart-damaging virus. What a business model!

As of early 2021, it was scientifically established beyond any doubt that COVID, like TB, is a fully airborne virus. This means that it spreads and can hang in the air like smoke; it means that contrary to early public health instructions, you can indeed become infected at distances greater than six feet, and that unsealed masks like the blue surgical ones often seen in hospitals are inadequate to prevent infection. (To be clear, surgicals are far better than nothing; they are simply not the proper type of mask to best prevent infection with a fully airborne disease. For that, you need a mask that forms a seal around your nose and mouth.)

The pandemic might have been controlled in early 2020 if the WHO had defaulted to the precautionary principle and acted as if COVID-19 could be airborne. Instead they confidently announced that COVID was droplet spread- as in, spread via coughs and sneezes- and discouraged people from proper mask wearing. Their incorrect guidance also trained people to adopt measures like social distancing and hand washing, which are inadequate to control COVID, yet are still mentioned in public health guidance to this day. Even some healthcare workers remain under the impression that surgical masks are a proper tool for prevention of COVID spread, a reality that can be observed

77 7

You might assume that the WHO had a very good reason to announce that COVID was droplet spread in 2020; I also made that incorrect assumption. In truth, the WHO and other bodies made a guess about the way COVID spread based on decades of bad science, as is fully explored in this fascinating paper, "What were the historical reasons for the resistance to recognizing airborne transmission during the COVID-19 pandemic?" I encourage you to read the entire thing, but essentially, the health establishment did not like to be challenged on something it had long considered conventional wisdom (most respiratory viruses are droplet spread), and those who dismissed those challenges additionally did not understand physics very well.

The WHO's announcement and subsequent bad public health advice should be a major scandal, not least because there was never any solid evidence demonstrating droplet spread of COVID-19. Professor Jose-Luis Jimenez, an aerosol expert and an author on the above linked paper, goes further and notes that "[Droplet transmission] has NEVER been demonstrated directly for any disease in entire history of medicine." The lessons of COVID could revolutionize infectious disease control, if the medical establishment would learn them. Instead, two and a half years after a watershed discovery, the medical establishment is still struggling with the game-changing revelation that most diseases thought to be "droplet-spread," like colds and flus, are in fact fully airborne.

Infection control is a primary duty of hospitals. If you're like me, meaning a human being with a brain and heart, you probably think allowing the leading cause of infectious disease death in the US to spread freely in hospitals is both immoral and incomprehensible. But of course, our media always sees two sides to every story. For example, we have the incredibly titled *Washington Post* piece, "Masks come off in the last refuge for mandates: The doctor's office". I want to take a moment to really appreciate the amount of bias packed into this short title. It's not "Masks come off in the place really sick people are forced to go," it's not "Masks come off as patients die," it's not "Masks come off as disabled people avoid care." No. It's "Masks come off in the last *refuge* for *mandates*." The last refuge for *mandates*! The hospital could more accurately be called "the last refuge for *people who might die of COVID*," but no, the subject being protected by masking in hospitals was the scary right-wing buzzword *mandates*. Wow! Another win for freedom.

patients, are framed as having one perspective about whether their doctors should purposely infect them with diseases, while the lovely professionals who simply "don't wanna" are framed as having an equally valid point of view.

Disabled, sick, immunocompromised and vulnerable people seeking care at a hospital, have the right not to be exposed to a virus that has killed 1.1 million Americans in 3.5 years. They have the right to seek care without having to fear that their care team will quite literally kill them with a preventable illness. Practitioners, on the other hand, have no right to compare the irritation of having to wear a mask at work with the moral injury of infecting vulnerable people who then go on to die at high rates.

No one has the right to compare the inconvenience of masks with the pain of parents begging their 6-year-old child's oncology care team to stop forcibly exposing their vulnerable daughter during hospital visits. If you are unaware, cancer patients undergoing treatment are often severely immunocompromised. Even prior to the pandemic, people did their best not to expose cancer patients to milder diseases like flus and colds. The family of the 6-year-old is considering moving to another state- if they can find one that still cares about not giving high-risk kindergarteners deadly viruses for the crime of getting cancer treatment.

While the US attempts to bury data around hospital acquired COVID infections, we fortunately have access to statistics from other parts of the world which haven't quite reached our level of Negligent Patient Murder Conspiracy. A study in BC found that as of November 2021, 1,619 patients were infected, and 274 patients died. A rate of 16.9%. A study looking at all of the hospital acquired COVID within the NHS system found at least 69,377 cases and 14,047 deaths- a staggering rate of 20.2%. Let's take a look at data collected only *after* the availability of vaccines- in 2022. Victoria Health Authority data from Australia found that that year, over 3,000 patients acquired COVID in the hospital in the province, and at least 344- just over 10%- died of their infections.

1 in 5. 1 in 10. Would you take those odds as a vulnerable patient in need of treatment?

Of course, looking only at deaths doesn't incorporate the other negative outcomes of COVID infection, including Long COVID, new onset health problems, delayed recovery

77 7

care have to risk any or all of the above?

I can't believe I have to say this, but infection control is not something that can happen part time, in some cases, or only during surges. As with gloves for bloodborne or hand washing for fomite transmission, protocols for airborne infection control are a set of practices implemented permanently and consistently to protect patients and healthcare workers alike. We don't stop hand washing because norovirus cases are down. We don't stop wearing gloves because HIV cases are down. As a doctor, if you're arguing that you should be able to expose patients to COVID because infection control annoys you, you should not be a doctor. Find a new career. I bet you'd love denying insurance claims. I bet you'd be a natural.

Making this picture even more hair-tearingly frustrating for disabled people avoiding healthcare settings is that the counter-argument for proper airborne infection control really is nothing beyond "don't wanna." There is no logical argument for allowing the spread of COVID-19 in healthcare settings. There is no scientific debate about the ways in which COVID is spreading. There is no risk analysis which shows that cancer patients or people who've just had heart attacks should consider a COVID infection to be no big deal. There is literally no excuse for this bizarre, unscientific mistreatment of patients other than gross incompetence, institutional negligence, and systemic ableism.

I should note that in the weeks and months since I have been made aware of and worked on this issue, I have met dozens of wonderful healthcare workers who are appalled by this medieval treatment and stand in solidarity with the many patients now avoiding care. Doctors, nurses, surgeons, researchers, aerosol experts and more are on the frontlines arguing against continued violation of patient and worker rights in the form of forcible exposure. While some healthcare workers are certainly sneering at infection prevention, many others are well aware that their profession puts them at high risk for long COVID, and that even spikes in short-term illness translate to absences and staff disruptions in an industry that was already suffering prior to the pandemic. A study in Brazil found the rate of Long COVID following infection among healthcare workers to be a shocking 27%. In this 2022 article, *Infection Control Today* notes that Long COVID is exacerbating worker shortages in all industries, but particularly healthcare.

77 7

contracted Long COVID, about one in five were no longer able to work due to ill health, and nearly half reported lost income. Three quarters of those surveyed attributed their infection to the workplace; the massive labor rights issues at play here have been largely ignored by most unions, with the notable exception of NNU. The nurses' union is currently organizing to push the CDC and its infection control advisory body, HICPAC, to fully acknowledge airborne transmission as they consider loosening guidelines even further.

I had the dubious honor of attending a HICPAC meeting yesterday, where after two hours of discussion that somehow evaded the elephant in the room, public commenters were finally given an opportunity to point it out. While none of the infection control experts had mentioned either COVID or aerosol transmission, every single commenter brought up both. Armed with studies, personal experiences, and common sense, commenters pointed out the obvious as the panel squirmed. COVID is airborne. So where is the airborne infection control? Mere hours after the meeting concluded, the CDC removed access to a publicly-available recording of the session.

The reluctance to adopt proper infection control in hospitals ultimately stems, not from employees, but from the financial interests of the hospitals themselves. Proper airborne infection control isn't limited to high-quality masks; you also need things like testing upon entry, space for isolation of positive cases and negative pressure rooms, improved indoor air quality and CO2 monitoring, and HEPA filtration. You'd need to test your staff consistently and give them paid leave when positive. All of that represents a large and costly investment; and our for-profit medical system is hardly known for its generosity nor its value for human lives.

As to the bewildering reality of practitioners who chose not to mask in their pathogen-laden workplace and continue to downplay the dangers of the virus, I would posit a psychological explanation. Since 2021, this country has been in the throes of a post-pandemic delusion that continues to disable and kill millions as COVID spreads and evolves. President Joe Biden declared the pandemic "over," and article after article after article informed us that continual reinfection was just fine for our health. As a result, most doctors, like most other people, went "back to normal." They sent their kids to

77 7

They are therefore, incredibly, personally, terrifyingly, invested in the hope that COVID is actually a cold.

I don't even know how to touch on the creepy "but we need to see smiles" thing, which is better evidence of some sort of psycholgical denial at play than I could possibly invent. Patients in hospitals don't need to see smiles to get proper medical care, obviously. They need infection control measures that prevent further illness. Is this a real argument?

Historically, doctors and the medical establishment are slow to adopt new infection control measures. If you've spent some time reading about the ongoing reluctance of medical bodies to acknowledge fully airborne transmission, you're probably familiar with the story of Ignaz Semmelweis by now. An OB-GYN who observed a significant reduction in mortality when he washed his hands, he attempted to introduce hand washing to other doctors as an infection control measure. He was met with mockery and rejection by the medical community, ultimately had a nervous breakdown, and died in a mental institution. The "Semmelweis Reflex," a phenomenon where people reflexively reject new information that would contradict their prior beliefs, is named for him.

I would characterize what is happening in hospitals- which, to put it plainly, is the murder of vulnerable people for convenience- as the point where the "back to normal" delusion collides with the inconvenient reality that vulnerable people exist in society. In any other context, it's easy to imagine that sick, disabled and immunocompromised people can simply remove themselves from danger, or properly mask themselves for short periods of time. In the hospital setting, we have to choose. Either COVID is not very dangerous, or we've been purposely exposing our friends, family, loved ones and communities to a disease that disables and kills. The mental burden of the latter is impossible to accept; so some working in the hospital system default to the former. Sad though it may be, I do not believe patients should have to cosplay 2019 for their practitioner's mental health.

Airborne infection control is not new. TB clinics implement it; nurses and doctors in TB clinics do not contract TB. Hospitals are refusing to implement COVID infection

77 7

system employing such stringent controls. If COVID is bad for sick people, might it be bad for everyone? If hospitals have to expend such resources to control infections, maybe schools should be doing so. If schools are doing it, why not workplaces? Or public transit? It's almost like controlling infections in hospitals would challenge the comforting narrative that constant COVID reinfection is just dandy for your health. So we pretend it's 2019. We pretend COVID is a cold. And our collective fantasy of "normality" continues to sicken and kill those who seek care.

77 Likes · 13 Restacks

The Gauntlet is a reader-supported publication.
To receive new posts and support my work,
consider becoming a free or paid subscriber.

7 Comments

Write a comment...

Dennis D. Aug 23

Doctors are just people who went to medical school, and often that was a long time ago. Like in all walks of life, some people are lifelong learners and others aren't. From personal experience, many doctors know less about the latest research on COVID effects and treatments than avid lay readers do. I was just told "don't bother with Paxlovid unless your symptoms are severe".

Hospitals are susceptible to lawsuits for hospital-acquired infections, but ONLY if it can be shown that they ignored protocols. That is the biggest driver behind several related realities:

* Reluctance of public health organizations to acknowledge airborne transmission and efficacy of masking

* Refusal of the CDC to create masking, air filtration, and isolation protocols that would open medical providers to liability if not followed

* Halting of COVID testing at hospital admission, where a negative test at admission would be damning evidence of HAI in court. Without it, plausible deniability.

*

77 7

1 reply

Lee Roberts Aug 23 · *edited Aug 23*

While I didn't work in health care, I was a teacher (mostly) from 1991 until 2019. Everything you say about hospitals applies equally or more so to schools. God only knows what struggling schools did with their air-quality mitigation money from the federal government. They probably bought cleaning supplies and paid teachers a smidgen more. None that I know of actually addressed HVAC problems.

COVID19 was the nail in the coffin of my career, not because I'm immunocompromised, because I have congenital hypertension and am not willing to jeopardize the uncommonly physically active life I enjoy in the out of doors when I'm not in classrooms. Selfish? You bet.

Thank you for saying so much so well. I'm only sorry that my early retirement budget for subscriptions is spent and it does not allow me to support your work directly right now.

LIKE (5) REPLY ···

5 more comments...

77 7